Supreme Court, U.S.
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# IN THE SUPREME COURT OF THE UNITED STATES

**October, 1995**

MARLENE NEGRETTE,

Petitioner,

v.

PRINCIPAL MUTUAL LIFE INSURANCE COMPANY and CHAMBERS DEVELOPMENT COMPANY, INC.,

Respondents

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Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

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## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED FOR REVIEW

1) Whether promises, made by an employer to a prospective employee, that the employee will be entitled to certain health insurance benefits, which promises induce an employee to accept employment, are enforceable against the employer, where the representations conflict with the terms of a health insurance policy provided by that employer to the employee? (Whether the Employee Retirement Income Security Act (ERISA) applies and preempts a claim of fraud in the inducement/inception?)

2) Whether a participant in an employee welfare benefit plan may be denied health insurance benefits based on an exclusion for pre-treated sicknesses, where the sickness was neither diagnosed nor treated before the effective date of the policy, and where the effective date of the policy was retroactively modified after litigation ensued.

## PARTIES TO THE PROCEEDING

Plaintiff-Petitioner:

MARLENE NEGRETTE,

Defendants-Respondents:

PRINCIPAL MUTUAL LIFE INSURANCE COMPANY and CHAMBERS DEVELOPMENT COMPANY, INC.

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## REFERENCE TO REPORT OF OPINION

There is no published opinion, official or unofficial, delivered in this case. The judgment and memorandum of the Ninth Circuit Court of Appeals are included in the Appendix at Tab A. The underlying Order Granting Summary Judgment and the Judgment of the District Court are included in the Appendix at Tab B.

## GROUNDS FOR JURISDICTION

The judgment to be reviewed in this action was entered by the Ninth Circuit Court of Appeals on December 23, 1994. (The Judgment and Memorandum are included in the Appendix at Tab A. The underlying Order Granting Summary Judgment and the Judgment of the District Court are included in the Appendix at Tab B.)

On July 10, 1995, the Ninth Circuit denied Appellant's Petition for Rehearing. (The Order Denying Petition is included in the Appendix at Tab C.)

No reliance on Rule 12.3 is made.

This Honorable Court has jurisdiction to review the judgment by writ of certiorari under 28 U.S.C. § 1254.

This action questions the applicability of 29 U.S.C. § 1001, et seq., the Employee Retirement Income Security

Act ("ERISA"). Alternatively, this action arises under 29 U.S.C. § 1001, et seq.

## RELEVANT STATUTES

The statutes relevant to this action are 29 U.S.C. §§ 1001, 1022, 1024, 1132, and 1144 and California Insurance Code § 650. The relevant ERISA statutes are included within the Appendix at Tab D. The relevant Insurance Code sections are included within the Appendix at Tab D.

## STATEMENT OF THE CASE

MARLENE NEGRETTE has been wrongfully denied health insurance benefits for cancer treatment. Although MARLENE NEGRETTE ("NEGRETTE") was neither treated for cancer nor diagnosed with cancer prior to the effective date of her policy, Respondents nevertheless denied coverage for Ms. NEGRETTE's cancer treatments by invoking an exclusion for pre-treated sicknesses which they refer to as a preexisting condition exclusion. Following litigation, Respondents, in an attempt to further rationalize and buttress their denial of coverage, changed the effective date of Ms. NEGRETTE's coverage to a date following the diagnosis of Ms. NEGRETTE's cancer.

The District Court found that the treatment received by Ms. NEGRETTE before January 12, 1992, treatment which was for a stomach ulcer, was treatment for her cancer. On appeal, the Ninth Circuit disagreed that the treatment received before January 12, 1992 would bar coverage for the cancer treatment; however, the Ninth Circuit upheld the district court's grant of summary judgment to Defendant, holding that the effective date of coverage was actually February 1, 1992 and not January 12, 1992. The Ninth Circuit found that Ms. NEGRETTE's employer's representations that coverage would be effective as of January 12, 1992 could not be enforced since they contradicted the plan which allegedly required that the policy be effective as of February 1, 1992. In so holding, the Ninth Circuit has created and imposed terms of a plan document where no plan document exists, and has held that the PRINCIPAL policy was the plan.

The Ninth Circuit has created immunity for fraud in the inception and inducement. Under the Ninth Circuit's holding, an employer can, with impunity, say and do anything to defraud an employee or induce an employee to be hired, as long as there is either no formal plan document adopted by the employer or the representations are not at odds with a formal plan document. Such a

holding violates the intentions of Congress in establishing ERISA to **protect** plan participants and beneficiaries. An employer should not be able to misrepresent to an employee that the employee has health insurance coverage, provide that coverage, and then retroactively terminate the coverage.

Summary of Facts

Ms. NEGRETTE was a healthy thirty-three year old wife and mother of three, who became employed by Security Bureau, Inc. ("SBI"), a subsidiary of Respondent CHAMBERS DEVELOPMENT COMPANY, INC. ("CHAMBERS") in October, 1991. Prior to beginning her employment with SBI, she was induced to work for SBI by promises made by SBI's agents that she would have health insurance coverage through her employment with SBI, effective on the ninetieth day after her date of hire.

Although the parent company, CHAMBERS, had filed and adopted a plan document, this document was, by its terms, inapplicable to employees of SBI. SBI had no formal, written plan document of its own and had taken no measures to file a plan document with the Department of Labor.

As a benefit of employment, Ms. NEGRETTE was to be allowed to participate in a group health insurance

policy issued and underwritten by defendant PRINCIPAL MUTUAL LIFE INSURANCE COMPANY "PRINCIPAL"). According to the representations of her employer, made to her before she was hired, Ms. NEGRETTE was required to wait ninety days, until January 12, 1992, before she could qualify for coverage under the PRINCIPAL policy. When SBI realized that the representations it had made to Ms. NEGRETTE were in conflict with the terms of the policy (the Principal policy provided coverage as of the first of the month following 90 days of employment, rather than on the ninetieth day), SBI, to its credit, insisted that its promises be enforced and that Ms. NEGRETTE be afforded coverage as of the ninetieth day. Ms. NEGRETTE was actually enrolled in the PRINCIPAL policy, effective January 12, 1992, with the full knowledge and acquiescence of PRINCIPAL, upon the insistence of SBI. In fact, PRINCIPAL began paying Ms. NEGRETTE's claims which were incurred immediately following January 12, 1992.

On January 2, 1992, two weeks prior to the effective date of the policy, Ms. NEGRETTE visited a family practice doctor, complaining of symptoms of stomach cramps, heartburn and weight loss. Her doctor formed the impression that Ms. NEGRETTE was suffering

from a stomach ulcer and prescribed Tagamet for her symptoms. About three weeks later, after NEGRETTE had been enrolled and eligible for coverage for thirteen days, on January 25, 1992, an ultrasound and other diagnostic tests revealed the presence of a growth on the outside of her stomach. Only after Ms. NEGRETTE was hospitalized and surgery was performed was it determined that she was suffering from cancer.

Despite the fact that Ms. NEGRETTE's cancer was neither diagnosed nor treated prior to January 12, 1992, and despite the fact that she had never been hospitalized or received services for cancer prior to the effective date of her policy, Respondent PRINCIPAL denied coverage for the treatment of Ms. NEGRETTE's cancer. The basis for that denial was the claim that the treatment Ms. NEGRETTE received for her ulcer constituted a "pre-existing condition" under the policy, and, thus, the cancer treatment was also excluded.

The policy that covered Petitioner Ms. NEGRETTE did not exclude coverage for "pre-existing conditions", but rather excluded "pre-treated sicknesses", stating in pertinent part: "A pre-existing condition is a sickness or injury for which a person was confined or received treatment or service in the 90-day period before becoming covered for

comprehensive medical expense coverage." This exclusion formed the sole basis for Respondents' denial of coverage, prior to the initiation of this action.

Plaintiff moved the court for Summary Judgment on the grounds that the treatment Ms. NEGRETTE received for her stomach problems was not cancer treatment, and, thus, the exclusion invoked by Defendant to deny benefits was inapplicable. Defendant also moved the court for Summary Judgment on the grounds that Ms. NEGRETTE's cancer was a pre-existing condition under the terms of the policy. The court granted Respondents' motion. An appeal was taken from the grant of summary judgment for the Respondents.

The Ninth Circuit seemingly disagreed with the district court's holding that Ms. NEGRETTE's doctor visit on January 2, 1992, before a diagnosis of cancer was made, invoked the pre-treated sickness exclusion. Nevertheless, the Ninth Circuit affirmed the district court, finding, on an issue never reached by the trial court, that the effective date of Ms. NEGRETTE's coverage was February 1, 1992, rather than January 12, 1992. Since Ms. NEGRETTE's cancer was diagnosed before February 1, 1992, the Ninth Circuit Court found that her cancer was a

pre-treated sickness and was therefore excluded from coverage.

Plaintiff/Appellant now petitions this Court for review of the Ninth Circuit's ruling on the issue of whether Ms. NEGRETTE's treatment of her cancer was a pre-treated sickness. Plaintiff/Appellant questions whether the effective date which was indisputably promised to be January 12, 1992 and which was in fact January 12, 1992, can be altered.

Review of the decision of the Ninth Circuit Court of Appeals is sought under Supreme Court Rule 10.1 on the grounds that there are special and important reasons therefor and, specifically under Rule 10.1(a) on the grounds that the Ninth Circuit Court of Appeals has rendered a decision in conflict with other United States Court of Appeals on the same matter and under Rule 10.1(c) on the grounds that the Ninth Circuit Court of Appeals has decided an important question of federal law which has not been, but which should be, settled by this Court.

## ARGUMENT

## AN INSURED CANNOT BE DENIED HEALTH INSURANCE COVERAGE BASED UPON AN EXCLUSION FOR PRE-TREATED SICKNESSES, WHERE THE INSURED IS NEITHER TREATED FOR NOR DIAGNOSED WITH THE PARTICULAR ILLNESS PRIOR TO THE EFFECTIVE DATE OF HER HEALTH INSURANCE POLICY

### I. An oral promise to provide insurance coverage is enforceable under state law; Ms. NEGRETTE'S claims are not preempted to governed by ERISA

If the effective date of the policy is correctly February 1, 1992, the District Court lacked jurisdiction over Ms. NEGRETTE's action to enforce an oral promise by her employer to provide insurance coverage. In Curtis v. Nevada Bonding Corp., 53 F.3d 1023 (9th Cir. 1995), a case decided after oral argument in this action, the Ninth Circuit held that an action to enforce an oral promise to provide insurance coverage is not governed by ERISA, where the promise to provide coverage and the subsequent reimbursement for incurred-costs existed independent of an ERISA plan.

In Curtis, the plaintiff was a new employee of the defendant employer. Id. Before plaintiff accepted

employment with defendant, plaintiff was promised health insurance coverage immediately, despite a 90 day waiting period under the Plan. Id. When defendant failed to provide insurance coverage as promised, plaintiff brought his action for breach of contract and misrepresentation, inter alia. Defendants removed the action and moved for summary judgment on the grounds that the claims related to the employee benefit plan, and thus were preempted by ERISA. The District Court granted the defendants' motion. On appeal, the Ninth Circuit held that plaintiff's claims were not governed by ERISA, and thus the District Court lacked jurisdiction. "The defendants' promise to provide insurance coverage to [plaintiff] . . . and their subsequent reimbursement to him for minor medical expenses did not create an ERISA plan." Id.

Similarly, in the instant action, if it is found that the effective date is February 1, 1992, plaintiff's claims should not be governed by ERISA. The oral promise of health insurance coverage inducing Ms. NEGRETTE to be employed by SBI is enforceable and claims for misrepresentation and fraud are not preempted by ERISA.

Further, the representations which were made to Ms. NEGRETTE were made prior to her employment and prior to the time when she became a participant in SBI's

plan. The misrepresentations constitute fraud in the inducement and in the inception, which because they predate Ms. NEGRETTE's participation in and enrollment in the plan cannot be subject to or preempted by ERISA. In effect, Ms. NEGRETTE lacks standing under ERISA if her policy did not become effective until February 1, 1992 and if she is precluded from enforcing the promises made to her that her coverage would be effective as of January 12, 1992. As the court in Curtis explained: "Moreover, without standing to enforce ERISA, there can be no ERISA preemption." Id., at 1027. See also Harris v. Provident Life and Accident Insurance Co., 26 F.3d 930 (9th Cir. 1994), Freeman v. Jacques Orthopaedic and Joint Implant Surgery Medical Group, Inc., 721 F.2d 654, 655 (9th Cir. 1983).

II. The effective date of Ms. NEGRETTE's coverage was January 12, 1992, not February 1, 1992.

A. Ms. NEGRETTE was offered coverage and was actually enrolled in the PRINCIPAL policy, effective January 12, 1992, in keeping with SBI's commitment and promises -- promises which were not prohibited by the terms of any applicable written plan document.

Assuming arguendo, that ERISA does govern the instant action, the Ninth Circuit's ruling that the plan's

effective date was February 1, 1992 is erroneous. When Ms. NEGRETTE was hired by SBI on October 14, 1991, there was no written plan in existence referencing, applying to or governing SBI employees. In fact, the only plan document which did exist and which the District Court found to govern SBI employees, applied exclusively to employees of CHAMBERS, not to employees of SBI. Virtually by sleight of hand, the Ninth Circuit fashioned a plan document out of thin air.

It is undisputed that SBI had no written plan document of its own. As a result, there was no plan document applicable to Ms. NEGRETTE or any other employees of SBI. Therefore, the representation by Ms. NEGRETTE's employer that there was coverage after 90 days is enforceable since it does not and could not contradict the terms of the SBI plan. There was no plan to contradict. Thus, the rule that estoppel does not apply to modify the written terms of a plan document falls by the wayside.

Further, it is of no avail to the Respondents that the policy also contained language contradicting the representations that coverage would be effective on the ninetieth day of employment. In the absence of a plan document, the policy does not substitute for or replace a

plan document. **A policy is not a plan document** and its existence does not create a written plan document where one does not exist. Dodd v. John Hancock Mutual Life Ins. Co. 688 F.Supp 564, 567 (E.D.Cal. 1988); Donovan v. Dillingham, 688 F.2d 1367, 1373 and 1375 (11th Cir. 1982). In the instant action, there is no dispute that a employee welfare benefit plan was established by SBI. Although the purchase of the PRINCIPAL policy demonstrates the existence of the SBI plan, it does not substitute for a formal plan document. If SBI had chosen to offer other benefits in addition to the benefits afforded under the PRINCIPAL policy, its intention to do so would not have been contained, memorialized, affected or prevented by the existence of the PRINCIPAL policy.

Since there was no written plan document in existence when Ms. NEGRETTE was hired, SBI was fully within its right to orally offer benefits to Ms. NEGRETTE, different than those contained in the PRINCIPAL policy. In the absence of a written plan, any representations regarding coverage simply could not have been inconsistent, contrary or contradictory to the non-existent plan document. Further, such representations could not have constituted an oral modification to a written ERISA plan document for SBI, as the Ninth Circuit held. Thus,

the representations that Ms. NEGRETTE would receive health insurance coverage after 90 days as an employee of SBI must be enforced.

Allowing the policy to substitute for a non-existent plan document is anathema to the requirements and reasoning for having plan documents to begin with. Plan documents are intended to formalize the intention of employers to provide benefits to their employees, so that benefits are defined and memorialized. The provisions of ERISA require that the plan provider set forth, in writing, a description of the employee benefit plan, including the plan's requirements respecting eligibility for participation and benefits. 29 U.S.C. § 1022(a)(1). Further, 29 U.S.C. § 1024(b)(1)(A) requires that the plan participants and beneficiaries be furnished with a written plan description, describing eligibility for participation. Plan documents are required to be filed with the Department of Labor, so that there is a clear and irrevocable understanding of what the plan intends, offers, and covers. None of these requirements were satisfied in the instant action. The failure of the employer to articulate the form and kind of benefits it would provide its employees in a plan document should not be allowed to become a shield, depriving the employee of coverage which is promised by the employer.

Policies can be changed as often as necessary and are not plan documents, but plans are relatively inert to change. The rule against varying the terms of a written plan, which are intended to prevent discrimination either preferentially in favor of or detrimentally against plan participants, is incapable of being accomplished where there is no plan document or where, as here, the rules governing the relations of the parties have never been codified in a plan document.

B. California Insurance Code, Section 650 prohibits Respondents from rescinding Ms. NEGRETTE's policy in the instant action.

Even if this Court finds that this action is governed by ERISA, California Insurance Code Section 650, which is addressed to and applicable only to the business of insurance, is a state law which regulates insurance and is, therefore, saved from ERISA preemption. 29 U.S.C. § 1144. California Insurance Code Section 650 mandates that the right to rescind a contract of insurance only be exercised **prior** to commencement of the action on the contract.

In the instant case, the Ninth Circuit ruled that Ms. NEGRETTE was not covered from January 12, 1992 to February 1, 1992, after coverage was, in fact, provided to

her during that period. This ruling allows Respondents to partially rescind the contract and to retroactively void the contract, in contravention of Insurance Code § 650. However, by failing to rescind the policy before a complaint was filed, Respondents are foreclosed from doing so and are prevented from claiming that the effective date of Ms. NEGRETTE's policy is any later than January 12, 1992. Thus, the Ninth Circuit erred in finding that the effective date of the policy was February 1, 1992.

Changes in the rationale for denying coverage which are made after an official denial are disallowed by the courts. McLaughlin v. Connecticut General Life Ins. Co. 565 F.Supp 434, 451 (N.D.Cal. 1985); Greany v. Western Farm Bureau Life Ins. Co. 973 F.2d 812, 821 (9th Cir. 1992). Here, the attempt by the Respondents to change the effective date of the policy to ensure that the treatment of cancer would be deemed preexisting, which attempt was made after litigation in this action ensued, cannot be upheld or allowed.

C. The reasonable expectations doctrine requires that the promise made by Ms. NEGRETTE's employer to afford coverage as of the ninetieth day of her employment be enforced.

In Saltarelli v. The Bob Baker Group Medical Trust, 35 F.3d 382 (9th Cir. 1994), the Ninth Circuit adopted and incorporated the well-settled principle and rule of common law known as the "reasonable expectation doctrine" into the federal common law of ERISA. The reasonable expectation of a participant will be effected, despite express language in a plan or policy which is at variance with that reasonable expectation, where the plan or insurer has, through acts or omissions, caused that reasonable expectation.

The facts of the instant action compel the application of the reasonable expectations doctrine, requiring that the promise made to Ms. NEGRETTE by her employer to afford coverage as of the ninetieth day be enforced. Ms. NEGRETTE not only had reason not to know of the terms of the pre-existing condition exclusion (as she had not been issued a policy) but also because she had received authoritative and credible representations that her coverage would be effective as of the ninetieth day following her date of hire. Certainly, it was reasonable for

her to believe and trust the representations of her employer. Her reasonable expectations of coverage on the ninetieth day would be violated if coverage were made effective as of the first of the month following the ninetieth day.

III. Ms. NEGRETTE is entitled to policy benefits under the PRINCIPAL policy, because the express language of the policy mandates that the treatment be for a specific sickness to be excluded from coverage.

Under the policy drafted by Respondent PRINCIPAL, if a policyholder received treatment, services or hospitalization for a sickness within 90 days before the effective date of the policy, subsequent treatment of the same sickness would not be covered under the policy. In the instant case, the uncontroverted evidence establishes that Ms. NEGRETTE was never treated, confined, or rendered services for ovarian/stomach cancer prior to the effective date of the policy. Nevertheless, Respondents contend that Ms. NEGRETTE's cancer is a pre-existing condition under the policy, and therefore her treatment for that condition should not be covered. As will be shown below, however, Respondents' argument is fatally flawed.

A. Under the plain and express language of the policy exclusion, Ms. NEGRETTE is entitled to coverage because she was never treated for ovarian/stomach cancer.

There is a general maxim of insurance law and contract construction which holds that words used in insurance policies must be interpreted in an ordinary and popular sense as they would be interpreted by an ordinary reasonable lay person of average intelligence and experience. Francheschi vs. American Motorists Ins. Co., 852 F.2d 1217, 1220, (9th Cir. 1988); citing, End Laboratories, Inc. vs. Hartford Ins. Group, 747 F.2d 1264, 1268 (9th Cir. 1984). Accordingly, the terms used in the subject policy must also be given the interpretation of an ordinary, reasonable, lay person.

In the instant case, coverage was denied on the basis of the "pre-existing condition" exclusion in Ms. NEGRETTE's policy. The exclusion for "pre-existing conditions" states: "A pre-existing condition is a sickness or injury for which a person was confined or received treatment or service in the 90-day period before becoming covered for comprehensive medical expense coverage."

Under the plain and express terms in the health plan drafted by Respondent PRINCIPAL, Ms. NEGRETTE's medical expenses would be covered by the policy unless

she suffered a sickness or injury for which she was "confined or received treatment or service in the 90-day period before becoming covered for comprehensive medical expense coverage." Looking at the policy language, as would a lay person of ordinary intelligence and experience, this Court must ask the following question: Was Ms. NEGRETTE confined or did she ever receive treatment or services for ovarian/stomach cancer, prior to the effective date of her policy? Manifestly, the answer to such an inquiry is an unequivocal "no".

Federal Courts have adopted the basic rule of insurance law that "... the insurer must prove facts that bring a loss within an exclusionary clause of the policy." McGee vs. Equicor Equitable HCA Corp. 953 F.2d 1192, 1205 (10th Cir. 1992) (citing other circuit court opinions). In the instant case, however, Ms. NEGRETTE's treatment for ulcerative disease does not fall within the pre-treated sickness exclusionary clause of the policy. Ms. NEGRETTE's cancerous condition was not diagnosed nor did she receive treatment or services for cancer at any time prior to the effective date of her policy, January 12, 1992.

B. Alternatively, if the exclusionary language used in the policy is subject to two interpretations, then it is ambiguous, and Ms. NEGRETTE is entitled to coverage.

The District Court held that the exclusionary clause at issue was not an unusual one and as such was not ambiguous. The Ninth Circuit disagreed with the District Court, and indicated that the pre-existing condition provision in the PRINCIPAL MUTUAL policy probably would not bar coverage for Ms. NEGRETTE's cancer because of her visit to her doctor on January 2, 1992. The Court found that the pre-existing condition exclusion in the policy was ambiguous, and, as such, must be construed against the drafter. (citing Pitcher v. Principal Mutual Life Ins. Co., 870 F.Supp. 903 (S.D. Ind. 1994)).

In the instant case, Respondents have defined the term "pre-existing condition" as a "pre-treated sickness"; "a sickness for which a person receives treatment or service." On its face, the language seems clearly inapplicable to the facts of the instant action. Webster's Ninth New Collegiate Dictionary defines "sickness" as a "**specific** disease" and defines "treatment" as "the techniques applied in a **specific** situation." Webster's Ninth New Collegiate Dictionary at pages 1094 and 1254 (Simon & Schuster, 1990)(emphasis added). The ordinary and reasonable lay

interpretation of the terms of the policy support Ms. NEGRETTE's position that she is entitled to coverage, because she was not treated for the specific sickness, cancer. However, should this Court agree with the Ninth Circuit in finding that the language of the policy is ambiguous, then coverage must nevertheless be extended to Ms. NEGRETTE, as a matter of law. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 541 (9th Cir. 1990).

The Ninth Circuit has determined that when construing an ambiguous provision in an ERISA insurance contract, the ambiguities in the policy must be construed against the insurer and in favor of coverage. Id. The Ninth Circuit's rationale for construing ambiguities against the insurer was based upon common-sense and the wide-spread adherence to the principle of contra proferentum. The Court explained its ruling, stating:

> Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common lay person to understand; if it fails to do this, it should not be allowed to take advantage of the very

> ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

Kunin, 910 F.2d at 540.

Here, the policy language appears clear and is manifestly inapplicable to the facts of the instant action. However, to the extent that Respondents argue an alternative construction of this policy language, an ambiguity is seen to exist. As such, since Respondents failed to clearly and adequately define what constitutes "a sickness for which a person receives treatment or service," the policy must be construed against them and in favor of coverage for Ms. NEGRETTE's cancerous condition.

## CONCLUSION

ERISA does not govern an action where, as here, an employee seeks to enforce an oral promise to afford coverage by the employer. Here, the District Court

improperly asserted jurisdiction and, thus, created immunity from liability where no immunity should exist.

Alternatively, even if ERISA is determined to govern the instant action, the Ninth Circuit erroneously denied coverage for Ms. NEGRETTE. Under the holding of the Ninth Circuit, ERISA, which was enacted to provide protection to and to safeguard the benefits of policyholders, has been turned on its head. Rather than provide protection, the Ninth Circuit has created immunity for misrepresentation. An employer should not be able to misrepresent to an employee that the employee has health insurance coverage, provide that coverage, and then retroactively terminate the coverage. Furthermore, Courts should not create and impose terms of a Plan document that does not exist and deny coverage where coverage is clearly intended by the parties.

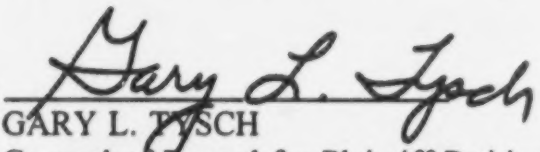
The balance originally achieved by the enactment of ERISA must be restored. These issues must now be

addressed by this Court. It is respectfully requested that the petition be granted and this matter be reviewed.

Dated this 23rd day of October, 1995.

Respectfully submitted,

LAW OFFICES OF LEIBOVIC & TYSCH

By: 

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# APPENDIX


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# APPENDIX A

## APPENDIX A

MARLENE NEGRETTE, Plaintiff-Appellant, v.

PRINCIPAL MUTUAL LIFE INSURANCE COMPANY

and

CHAMBERS DEVELOPMENT COMPANY, INC.,

Defendants-Respondents.

No. 94-55014

NOT FOR PUBLICATION

United States Court of Appeals, Ninth Circuit

Filed and entered May 23, 1995

APPEAL FROM the United States District Court for the Central District of California

Gary L. Taylor, District Judge, Presiding

Argued and Submitted April 4, 1995, Pasadena, California

Before: D.W. NELSON, CANBY Circuit Judges, and TANNER, District Judge.** [1/]

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

** Honorable Jack E. Tanner, Senior United States District Judge for the Western District of Washington, sitting by designation.

MEMORANDUM

Plaintiff-Appellant MARLENE NEGRETTE appeals the district court's grant of summary judgment in favor of defendant-appellees Principal Mutual Life Insurance Company ("Principal Mutual") and Chambers Development Company, Inc. ("Chambers") in NEGRETTE's action challenging the denial of her claim for medical benefits pursuant to Section 502(a) of the Employee Retirement Insurance Security Act ("ERISA"), 29 U.S.C. § 1132(a). The district court ruled that NEGRETTE's claim for coverage was properly excluded under the preexisting condition provision in her group health insurance policy because the court found that on January 2, 1992, NEGRETTE had received treatment for the symptoms of her then undiagnosed cancer. On appeal, NEGRETTE claims that the district court erred in interpreting the preexisting condition clause of the insurance policy. We have jurisdiction pursuant to 28 U.S.C. § 1291, and we affirm.

I.

The parties are familiar with the facts of the case; we will not recite them here. We review a grant of summary judgment de novo. Jesinger v. Nevada Federal

Credit Union, 24 F.3d 1127, 1130 (9th Cir. 1994). WE must determine, viewing the evidence in the light most favorable to NEGRETTE, whether there are any genuine issues of materials fact and whether the district court correctly applied the relevant substantive law. Id. This court may affirm a grant of summary judgment on any ground supported in the record. Iolab Corp. v. Seaboard Sur. Co., 15 F.3d 1500, 1504 (9th Cir. 1994).

Because Chambers and Principal Mutual have not alleged that the ERISA plan granted them discretionary authority to determine eligibility for benefits or to construe the terms of the plan, this court reviews their decision to deny NEGRETTE's claim de novo. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Watkins v. Westinghouse Hanford Co., 12 F.3d 1517, 1524 (9th Cir. 1994).

II.

We need not address whether NEGRETTE's visit to Dr. Adatto on January 2, 1992, constituted "service or treatment" for her cancer. There is no dispute that NEGRETTE was treated for her cancer on January 22-25, 1992. Because we find that NEGRETTE's health coverage under the ERISA plan offered by Chambers did not begin

until February 1, 1992, we conclude that her claim for coverage of her cancer treatment was properly excluded under the plan's preexisting condition clause.

It is undisputed that the Principal Mutual group policy that was in place when NEGRETTE was hired by SBI established the existence of an ERISA employee welfare benefit plan, under which NEGRETTE was a participant or beneficiary. See Kanne v. Connecticut General Life Ins. Co., 867 F.2d 489, 492 (9th Cir. 1988) (per curiam), cert. denied, 492 U.S. 906 (1989). Chambers and principal Mutual contend that the unambiguous eligibility provision of that policy bars NEGRETTE's assertion that her coverage began on January 12, 1992. See Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812, 822 (9th Cir. 1992). NEGRETTE asserts, however, that the Principal Mutual Insurance policy was not the ERISA plan document and that there was no written plan applicable to NEGRETTE when she began her employment with SBI. Thus, she argues, Ronald Kane's representations that her coverage would begin on January 12, 192, estopped Chambers from claiming that her coverage did not begin until February 1, 1992.

ERISA requires that "[e]very employee benefit plan . . . be established and maintained pursuant to a written

instrument." 29 U.S.C. § 1102(a)(1). However, "there is no requirement that the documents claimed to collectively form the employee benefit plan be formally labelled as such. WE see no reason to require an employer to comply with a formality not imposed by law." Horn v. Berdon, Inc. Defined Benefit Pension Plan, 938 F.2d 125, 127 (9th Cir. 1991). Accordingly, in Greany, we looked to the provisions of the group health insurance policy to determine whether the "written terms of the plan" were ambiguous. Greany, 973 F.2d at 820-822 and n.10; see also Qualls By and Through Qualls v. Blue Cross of California, Inc., 22 F.3d 839, 843 (9th Cir. 1993); Henkin v. Northrop Corp., 921 F.2d 864, 870 (9th Cir. 1990); Accord Gable v. Sweetheart Cup Co., 35 F.3d 851, 855 (4th Cir. 1994), cert. denied, 1195 WL 61526 (U.S. Apr. 3, 1995); Musto v. American General Corp., 861 F.2d 897, 901 (6th Cir. 1988), cert. denied, 490 U.S. 1020 (1989).

The fact that Kane's promise to NEGRETTE was made before she had received any written plan documents is not relevant. See Watkins v. Westinghouse Hanford Co., 12 F.3d 1517, 1523 (9th Cir. 1994); 29 U.S.C. § 1024(b). The evidence is undisputed that Chambers cited the Principal Mutual group policy in the Form 5500 Chambers

filed with the Secretary of Labor. See 29 U.S.C. §§ 1023, 1024(a). Moreover, the summary plan description ("SPD") that Chambers provided to NEGRETTE, pursuant to 29 U.S.C. § 1024(b)(1)(A), explained that "The plan is established through a Group Policy issued by [Principal Mutual] for the Planholder, Chambers Development Company, Inc.," and that "[a]s a covered member of the plan, your rights and responsibilities are determined by the provisions of the Group Policy." Lastly, the eligibility provision included the SPD booklet was completely consistent with that of the insurance policy. Thus at the time of NEGRETTE's hiring, the Principal Mutual group policy, applicable to nonunion workers scheduled to work at least 30 hours per week at SBI, constituted the written plan document.

Because the eligibility provision of that policy is unambiguous, NEGRETTE cannot assert an equitable estoppel claim that "would result in a payment of benefits . . . inconsistent with the written plan," Greany, 973 F.2d at 822. Thus, the effective date of her coverage was February 1, 1992. The undisputed fact that NEGRETTE received "treatment or services" for her cancer on January 22-25, 1992, renders her cancer a preexisting condition even under her interpretation of the exclusionary provision.

III.

Although the preexisting condition provision in the Principal Mutual policy probably would not bar coverage for NEGRETTE's cancer because of her visit to Dr. Adatto on January 2, 1992, [2]LINCOLN HOSPITAL MEDICAL CENTER EMPLOYEE BENEFIT PLANLINCOLN HOSPITAL MEDICAL CENTER EMPLOYEE BENEFIT PLANLINCOLN HOSPITAL MEDICAL CENTER EMPLOYEE BENEFIT PLAN we need not resolve this issue in this case. Because the effective date of her coverage was February 1, 1992, the "treatment or service" for cancer that she received on January 22-25, 1992, renders her cancer a preexisting condition under the plain language of the exclusionary provision. Accordingly, the judgment of the district court is AFFIRMED.

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1. See Pitcher v. Principal Mutual Life Ins. Co., 870 F. Supp. 903 (S.D. Ind. 1994) (holding that the identical preexisting condition clause was ambiguous and must be construed against the insurer).

# APPENDIX B

**APPENDIX B**

MARLENE NEGRETTE, Plaintiff, v.

PRINCIPAL MUTUAL LIFE INSURANCE COMPANY and CHAMBERS DEVELOPMENT COMPANY, INC.,

Defendants.

No. SA CV 92-463 GLT

United States District Court

Central District of California

Filed and entered November 23, 1993

Defendant's Motion for Summary Judgment is GRANTED for the reasons stated in the Court's tentative decision announced at the hearing on this motion. The Court concludes that the pre-existing condition exclusion applied in this case. Defendants are directed to submit a proposed judgment within five days.

DATED: 11/23/93 s/GARY L. TAYLOR
United States District Judge

# APPENDIX C

## APPENDIX C

MARLENE NEGRETTE, Plaintiff-Appellant v.
PRINCIPAL MUTUAL LIFE INSURANCE COMPANY
and CHAMBERS DEVELOPMENT COMPANY, INC.,
Defendants-Respondents.

No. 94-55014

United States Court of Appeals, Ninth District

Submitted June 7, 1995

Filed and entered July 10, 1995

ORDER

Before D.W. NELSON, CANBY Circuit Judges, and TANNER, District Judge.*[3/]

Appellant's Petition for Rehearing filed June 7, 1995 is DENIED.

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* Honorable Jack E. Tanner, Senior United States District Judge for the Western District of Washington, sitting by designation.

# APPENDIX D

# APPENDIX D

## UNITED STATES CODE ANNOTATED

## TITLE 29. LABOR

## CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

## SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS

## SUBTITLE A--GENERAL PROVISIONS

Current through P.L. 103-210, approved 12-20-93

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power.

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate

character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that is therefore

desirable in the interest of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries.

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal courts.

(c) Protection of interstate commerce, the Federal taxing poser, and beneficiaries by vesting of accrued benefits, setting minimum standards funding, requiring termination insurance.

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing

power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

**UNITED STATES CODE ANNOTATED**

**TITLE 29. LABOR**

**CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM**

**SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS**

**SUBTITLE B--REGULATORY PROVISIONS**

**PART 5--ADMINISTRATION AND ENFORCEMENT**

Current through P.L. 103-210, approved 12-20-93

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provisions

of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025 (c) of this title;

(5) except as otherwise provided in subsection (b) of this section , by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169 (a)(2)(A) of this title); or

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a) (5) of this section with respect to a violation of , or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Refusal to supply requested information; failure to comply with notice requirements; penalties

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e) (1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such an administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 per day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1000 for each violation by any person of section 1021(f)(1) of this title. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation. The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons,

subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021 (f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall

have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon the Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section

which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a pan which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each transaction (as defined in section 4975(f)(4) of Title 26 for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26 within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an

amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28, but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(L) Civil penalties on violations by fiduciaries

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan without severe financial hardship unless a waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

**UNITED STATES CODE ANNOTATED**

**TITLE 29. LABOR**

**CHAPTER 18--EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM**

**SUBCHAPTER I--PROTECTION OF EMPLOYEE BENEFIT RIGHTS**

**SUBTITLE B--REGULATORY PROVISIONS**

**PART 5--ADMINISTRATION AND ENFORCEMENT**

Current through P.L. 103-210, approved 12-20-93

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, and the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. ss 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section--

(i) in the case of any employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare

arrangement subject to an exemption under subparagraph (B), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an

employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State, qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent enforced by qualified medical child support orders.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistant approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

**UNITED STATES CODE ANNOTATED**

**TITLE 29**

**LABOR**

**CHAPTER 18-RETIREMENT INCOME SECURITY**

**SUBCHAPTER (a)(1) PLAN DESCRIPTION AND SUMMARY PLAN DESCRIPTION**

§1022. A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with Section 1024(b)(1) of this title.

**UNITED STATES CODE ANNOTATED**

**TITLE 29**

**LABOR**

**CHAPTER 18**

**RETIREMENT INCOME SECURITY**

**SUBSECTION (b) PUBLICATION OF SUMMARY PLAN DESCRIPTION AND ANNUAL REPORT TO PARTICIPANTS AND BENEFICIARIES OF PLAN**

Publication of the summary plan descriptions and annual reports all be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modifications and changes referred to in section 1022(a)(1) of this title-

(A) Within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits.

## CALIFORNIA INSURANCE CODE

## SECTION 650

## CHAPTER 9

## RIGHT TO RESCIND; TIME TO EXERCISE

Whenever a right to rescind a contract of insurance is given to the insurer by any provision of this part such right may be exercised at any time previous to the commencement of an action on the contract. The rescission shall apply to all insureds under the contract, including additional insureds, unless the contract provides otherwise.